



Special Medical Needs Voluntary Registry Form

Please complete form and return to OR mail to:
Pitt County Emergency Management, 1717 West 5th St., Greenville, NC 27834
For more information, call 252-902-3950

Please print clearly

NAME Last: _____ First _____ Middle _____

Street Address: _____

City: _____ State: _____ ZIP: _____ County of residence: _____

Mailing address if different than above: _____

Do you live in a mobile home? Yes No

If yes, please provide park name: _____

Phone #: _____ Alternate Phone #: _____

DOB: _____ Age: _____ (years) Sex: Male Female Weight: _____ lbs. Height _____ (ft.) _____ (in.)

Primary Language: _____

Living Situation: Alone Relative Care Giver Other _____

Your Care Giver MUST accompany you to the shelter. Please provide their information below.

Name of Care Giver: _____

Relationship to Care Giver: _____ Phone: _____

Emergency Contact: Name: _____ Phone: _____

(If other than Caregiver)

Have you made arrangements for your pets? They ARE NOT allowed at the shelters.

Transportation Needs

Can you get to an Evacuation Shelter? Yes No

If no, please check the appropriate transportation needed.

Car Wheelchair Van Ambulance Other: _____

Medically Dependent on Electricity:

O2 Concentrator Feeding Pump Suction Other: _____

Oxygen Dependent: Oxygen Type: Liquid Bottle Room Air

24 hour Only Overnight
 Intermittent CPAP

Mode of administration: Nasal Cannula Mask
Liters flow: _____ L/minute: _____

Medical Needs/ Condition:

<input type="checkbox"/> Assistance with medications	<input type="checkbox"/> Mental Health Problems: _____	List any assistive devices such as glasses, cane, and hearing aid.			
<input type="checkbox"/> Medication requiring refrigeration Type: _____	<input type="checkbox"/> Cognitive impaired: _____ (i.e., Alzheimer's, dementia)		<input type="checkbox"/> Vision Loss/ Impaired _____		
<input type="checkbox"/> Assistance needed with wound care: Specify: _____	<input type="checkbox"/> Has behavioral challenges: Specify: _____		<input type="checkbox"/> Hearing Loss/ Impaired _____ <input type="checkbox"/> Speech Impaired _____		
<input type="checkbox"/> Incontinence: please specify	<input type="checkbox"/> Bowel	<input type="checkbox"/> Bladder			
<input type="checkbox"/> Mobility Impaired: please specify	<input type="checkbox"/> Walker	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Bedridden
<input type="checkbox"/> Dialysis Dependent: please specify	<input type="checkbox"/> Peritoneal (PD)	<input type="checkbox"/> Hemodialysis	Schedule: _____		
<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Diabetes Type 2				
<input type="checkbox"/> Other Health Impairments or Medical Conditions not previously listed: _____					
<input type="checkbox"/> Known Food or Drug allergies: _____					
List (or attach a list of) Routine Medications, both prescription and over the counter					

<input type="checkbox"/> Other Medical Equipment: please specify _____					

Medical Contact Information:

Primary Doctor: _____	Phone: _____
Home Health Provider _____	Phone: _____
Home Medical Equipment Provider: _____	Phone: _____
Oxygen Company: _____	Phone: _____
Pharmacy Name: _____	Phone: _____

Conditions and Authorization to Release Information, Including Protected Health Information

Please read and initial each of the following:

- I understand that my participation in this registry is voluntary and that all information that I provide will only be used for disasters and emergency planning and response purposes.
- I understand that at any time I may ask that my name be removed from the Registry by sending a written request to Pitt County Emergency Management.
- I understand that while registering this information my help emergency responders to know and understand my emergency needs, registration does not guarantee any particular emergency services or any level of emergency services during an emergency or disaster.

- I grant permission to emergency medical providers, transportation providers and other emergency responders to enter my residence in an emergency, to provide care and to disclose the information I have provided as needed to respond to my emergency needs. This is not intended to limit a responder’s ability to enter or respond to an emergency as allowable by law.
- I grant permission to medical providers, transportation agencies and others to provide care and disclose information, as needed, to respond to my emergency needs.
- I authorize Pitt County to use, disclose or release information to other emergency response or human services agencies or officials as necessary to respond to my emergency needs.
- I understand that I must have an adult caregiver with me during my stay at a shelter that will provide routine care to me, the same as would be performed in my own home.
- I understand that I am responsible for making my own emergency preparations. This may include, but is not limited to, provision of prescription medications, oxygen supplies, medical equipment and special dietary items that I may need if I evacuate from my home.
- I understand that I am responsible for all costs associated with medical transportation and/or medical sheltering that are incurred beyond the scope of the emergency event. These costs cannot be assumed by Pitt County or any of the emergency response agencies.
- I understand that assistance will only be provided for the duration of the evacuation, emergency or disaster and that alternative arrangements should be made in advance in the event that I am unable to return to my home.
- I understand that in the event that I am unable to return to my home that I will be responsible for any additional transportation or hospital expenses.
- I understand that I should call 911 if I am in an emergency, even though I have submitted information to the registry.

I hereby confirm and attest that the information provided in this registration is correct and that should the information that I have provided change, I will promptly update the registry. I have had the full opportunity to read and consider the contents of this Authorization. I understand that, by signing this form below, I am confirming my authorization that the Pitt County Emergency Management Office may disclose to the organizations named in this form the information described in this form.

Signature of applicant: _____ Date: _____

Print Name: _____

****If the person filling out this form is not the Special Medical Needs individual, please answer the following:***

Name: _____ Phone: _____

Relationship: _____

Do not write below this line: For Internal Use Only

Date Rec'd: _____ Notes: _____